



# Eligibility Review Questions and Answers

If you need help reading this, please ask the receptionist for help.

## People Helping People



Cash Assistance



Food Assistance



Medical Assistance



General Assistance  
for the  
Unemployable



Nursing Home Care  
or Assisted Living

### Q. How do I apply for benefits?

**A.** It's easy - just fill out the application. Check the box on the top of page 2 if you need help completing this form. The date you apply affects how soon your benefits start. If you are applying for someone else, complete the questions with that person's information. **We need at least your name, address, and signature on page 2 to start the application process and pages 3 and 4 to complete the application process. If you don't have an address, please talk to the receptionist when you turn in your application so we can find out how to contact you.** You can turn the form in to the receptionist or mail it to your local Community Services Office (CSO). For long-term care services, mail the form to your local Home and Community Services Office. You will not need an interview if you are applying for medical only.

### Q. What if I need food right away?

**A.** Fill-in Questions 1 through 14, and take it to the receptionist now. If you are not in the local office, mail this application or bring it into the local office. You may get food assistance within five (5) days from the date we get your application if:

- You show proof of your identity; **and**
- Your household has very little income or resources; **or**
- Your household's income and resources are not enough to cover your monthly rent and utilities combined; **or**
- Your household includes a destitute migrant or seasonal farm worker.

### Q. When will my benefits begin?

**A.** If you are eligible for cash assistance, your benefits start on the date we get all the information to decide you are eligible. If you are eligible for food benefits, the amount of your benefits is usually based on the date we get the application. For medical, the date your coverage begins depends on which medical program you qualify for and the date we get your application. You may ask for help with some past medical bills.

#### Important Information about Immigration Status and Social Security Numbers

- You can apply for benefits for part of your family even if some family members may be ineligible because of immigration status. Washington State has some medical programs for people without Social Security Numbers or proof of immigration status.
- If you need cash or food assistance, you need to provide Social Security numbers or immigration status only for people who are applying. You may still provide your Social Security number voluntarily and we will use it only to verify needed information to determine eligibility, such as your income. If you choose not to provide your Social Security number or immigration status, your income and resources must still be verified if needed to determine eligibility.

The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, sex, religion, national origin, or political beliefs. Persons with disabilities who require alternative means for communication of program information (Braille, large print, audio tape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 14th and Independence Avenue S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.





## ELIGIBILITY REVIEW

☐ If you need help filling out this form,  
please check this box and take it to the receptionist.

### FOR OFFICE USE ONLY

DATE  
RECEIVED

INITIALS

1. FIRST NAME	MIDDLE INITIAL	LAST NAME	SIGNATURE (REQUIRED)	2. CLIENT ID NUMBER (IF KNOWN)
3. STREET ADDRESS WHERE YOU LIVE				4. HOME OR MESSAGE PHONE NUMBER
5. MAILING ADDRESS (IF DIFFERENT)				6. WORK PHONE NUMBER
9. I am applying for (check all that apply): <input type="checkbox"/> Cash <input type="checkbox"/> Nursing Home Care <input type="checkbox"/> Other (please list): <input type="checkbox"/> Food <input type="checkbox"/> Drug and Alcohol Treatment <input type="checkbox"/> Medical <input type="checkbox"/> COPES (Assisted Living or In-Home Care)				7. E-MAIL ADDRESS
10. How much money do you expect your household to get this month: \$				8. CELL PHONE NUMBER
11. How much money does your household have in cash and bank accounts: \$				
12. How much does your household pay for rent or mortgage: \$				
13. What utilities does your household pay for: <input type="checkbox"/> heating/cooling <input type="checkbox"/> telephone <input type="checkbox"/> other:				
14. Is anyone in your household a seasonal or migrant farm worker? <input type="checkbox"/> Yes <input type="checkbox"/> No				

**FOR OFFICE USE ONLY - Household eligible for expedited service:** ☐ Yes    ☐ No    **Screener's Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

15. I need a phone interview because I'm:    ☐ Elderly    ☐ Disabled    ☐ Working    ☐ Other hardship: \_\_\_\_\_

16. ☐ I need a translator. I speak: \_\_\_\_\_ or ☐ sign; I want my letters in: \_\_\_\_\_

17. If applying for food assistance, how many people in your household do you buy and prepare food for? \_\_\_\_\_

18. In the past 30 days, I got cash, food, or medical assistance from another state or source:    ☐ Yes    ☐ No

19. I or someone I'm applying for was convicted of a drug-related felony committed after 08/21/96:    ☐ Yes    ☐ No

20. I am or someone I'm applying for is fleeing from the law to avoid going to court or jail for a felony crime:    ☐ Yes    ☐ No

21. I or someone in my household have a (check all that apply):    ☐ Pregnancy; due date: \_\_\_\_\_  
☐ Medical emergency    ☐ Eviction notice    ☐ Utility shutoff or no heat  
☐ Domestic violence situation    ☐ Disability (list type): \_\_\_\_\_

**22. The following information is voluntary and will not be used to determine your eligibility for benefits.**  
My ethnic background is Hispanic or Latino:    ☐ Yes    ☐ No    I consider my race to be (check **all** that apply):    ☐ White  
☐ Black or African American    ☐ Asian    ☐ Native Hawaiian or Other Pacific Islander  
☐ American Indian or Alaska Native; tribe name: \_\_\_\_\_ ☐ Other (list): \_\_\_\_\_

23. List everyone in your household even if you are not applying for them (attach additional sheets, if necessary).

NAME (FIRST, MIDDLE, LAST)	HOW IS THIS PERSON RELATED TO YOU?	DO YOU WANT BENEFITS FOR THIS PERSON? YES NO	BIRTHDATE	OPTIONAL FOR NON-APPLICANTS			SEX M OR F
				U.S. CITIZEN? YES NO	IF NOT A CITIZEN, IS THERE A DOCUMENT TO SHOW STATUS? YES NO	SOCIAL SECURITY NUMBER	
	<b>Myself</b>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		



APPLICANT'S NAME	SOCIAL SECURITY NUMBER	CLIENT IDENTIFICATION NUMBER
------------------	------------------------	------------------------------

### I. General Information

- Everyone I'm applying for lives in Washington State: ☐ Yes ☐ No If yes, since (list date): \_\_\_\_\_
- I am or someone in my household is a sponsored alien: ☐ Yes ☐ No
- Someone is temporarily out of my home: ☐ Yes ☐ No If yes, who (list): \_\_\_\_\_
- I am or someone in my household is a veteran or dependent or spouse of a veteran (living or deceased): ☐ Yes ☐ No
- I am living in: ☐ My own house or apartment ☐ Adult Family Home ☐ Group Home  
☐ Facility (list type): \_\_\_\_\_ ☐ Other: \_\_\_\_\_
- I am: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

### II. Medical and Health Insurance Information

#### I or we (check appropriate box):

- Have health problems that prevent me (us) from working ☐ Yes ☐ No
- Have unpaid medical bills ☐ Yes ☐ No
- Need help with unpaid medical bills for any of the past three (3) months ☐ Yes ☐ No
- Plan to enter, are in, or recently left a medical facility (such as a hospital or nursing home) ☐ Yes ☐ No
- Have health insurance (including Tricare or Long-Term Care Insurance) ☐ Yes ☐ No
- Have Medicare (NOTE: This is **not** the same as having medical coupons) ☐ Yes ☐ No
- Had an accident requiring medical care ☐ Yes ☐ No

### III. Resources

**You do not need to complete this section if you are applying for Children's Medical or Pregnancy Medical ONLY.**

In addition to the items listed below, other examples of resources include cash, money held by others, sales contracts, livestock, crops, and business equipment.

- I, my spouse, or someone I'm applying for has resources: ☐ Yes ☐ No If yes, please list them below:

TYPE OF RESOURCE?	WHOSE RESOURCE IS IT?	WHERE IS THE RESOURCE?(E.G., NAME OF BANK)	AMOUNT OR VALUE	WHOSE RESOURCE IS IT?	WHERE IS THE RESOURCE?(E.G., NAME OF BANK)	AMOUNT OR VALUE
Checking account(s)			\$			\$
Savings or credit union account(s)			\$			\$
CD or money market account(s)			\$			\$
Trusts or annuities			\$			\$
Stocks, bonds, or mutual funds			\$			\$
Retirement fund or IRA			\$			\$
Burial funds, plans, or plots			\$			\$
Life insurance			\$			\$
Property			\$			\$
Other:			\$			\$
Other:			\$			\$

- I, my spouse, or someone I'm applying for has sold, traded, given away, or transferred a resource in the last five (5) years (includes transfers into trusts or life estates): ☐ Yes ☐ No If yes, what: \_\_\_\_\_ When: \_\_\_\_\_

- I have or someone I'm applying for has the following vehicles (including trucks, vans, boats, and trailers):

YEAR (E.G., 1980)	MAKE (E.G., FORD)	MODEL (E.G., ESCORT)	IS THIS VEHICLE LEASED?	I (WE) USE THIS VEHICLE FOR MEDICAL PURPOSES.	I (WE) STILL OWE ON THIS VEHICLE.
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



#### IV. Income

1. I, my spouse, or someone I'm applying for has income: ☐ Yes ☐ No If yes, please complete this section:

EMPLOYER'S NAME AND PHONE NUMBER

GROSS AMOUNT RECEIVED (DOLLAR AMOUNT BEFORE TAXES)

\$ \_\_\_\_\_ every: ☐ Hour ☐ Week ☐ Two weeks

Is this job self-employment? ☐ Yes ☐ No

☐ Twice a month ☐ Month Hours per week: \_\_\_\_\_

Who makes the income:

Pay dates (e.g., 1st and 15th, or every Friday): \_\_\_\_\_

EMPLOYER'S NAME AND PHONE NUMBER

GROSS AMOUNT RECEIVED (DOLLAR AMOUNT BEFORE TAXES)

\$ \_\_\_\_\_ every: ☐ Hour ☐ Week ☐ Two weeks

Is this job self-employment? ☐ Yes ☐ No

☐ Twice a month ☐ Month Hours per week: \_\_\_\_\_

Who makes the income:

Pay dates (e.g., 1st and 15th, or every Friday): \_\_\_\_\_

2. I, my spouse, or someone I'm applying for quit a job within the past 60 days. ☐ Yes ☐ No

3. OTHER INCOME	WHO GETS THE INCOME?	GROSS MONTHLY AMOUNT	WHO GETS THE INCOME?	GROSS MONTHLY AMOUNT
Unemployment benefits		\$		\$
Social Security		\$		\$
Supplemental Security Income (SSI)		\$		\$
Child support or spousal maintenance		\$		\$
Retirement or pension		\$		\$
Veterans Administration (VA) or military benefits		\$		\$
Labor and Industries (L&I) or insurance benefits		\$		\$
Trusts or annuities		\$		\$
Other:		\$		\$

#### V. Monthly Expenses

RENT	MORTGAGE	SPACE RENT	HOMEOWNER'S INSURANCE	PROPERTY TAXES	PROPERTY ASSESSMENTS
\$	\$	\$	\$	\$	\$

Utilities (check all that apply): ☐ Electricity (**not heat**) ☐ Phone ☐ Heating (gas, electric, oil) ☐ Water, sewer, garbage

Another person or agency helps me pay either all or part of my shelter costs: ☐ Yes ☐ No

If yes, who: \_\_\_\_\_ What expense: \_\_\_\_\_ Amount they pay: \$ \_\_\_\_\_

I (we) pay or are supposed to pay (check all that apply):

☐ Child care or dependent care Monthly amount: \$ Who pays:

☐ Child support Monthly amount: \$ Who pays:

☐ Medical bills Monthly amount: \$ Who pays:

#### DECLARATION AND SIGNATURE

I have read (or had explained to me) my rights and responsibilities and received a copy of the Client Rights and Responsibilities, DSHS 14-113(X). I must report changes as required by the department. I must provide proof I am eligible. DSHS may help me get the proof or contact other persons or agencies for it. By getting Temporary Assistance to Needy Families (TANF) or medical care benefits, I assign certain rights to child or medical care support to the State of Washington. I declare under penalty of perjury that the information I gave in this application is true, correct, and complete to the best of my knowledge. I understand that I can be criminally prosecuted if I incorrectly receive cash, food, or medical assistance because I have willfully made a false statement or willfully failed to report something I should report. Only the applicant must sign if applying for Food Assistance. If applying for cash or medical help, all adult household members must sign.

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF OTHER ADULT APPLICANT	DATE
SIGNATURE OF HELPER OR REPRESENTATIVE	DATE	SIGNATURE OF WITNESS IF SIGNED WITH AN "X"	DATE

